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THE PRISONER IN A PRIVATE HOSPITAL SETTING: WHAT PROVIDERS SHOULD KNOW

JEFFREY NATTERMAN* & PAMELA RAYNE**

I. INTRODUCTION

Prisoner health care rights have long been debated, and accordingly, there are countless journal articles and judicial decisions describing their various nuances.¹ Despite the scholarship that has penetrated various issues confronting prisoner medical management, one under-reported subject area requires further exploration. The privately hospitalized prisoner-patient is clinically managed based on the same standard of medical care established for the general population, but the prison context presents additional complicating factors.²

Medical providers are expected to follow ethical clinical practice guidelines established by national medical societies, and base their practices on well-established, evidenced-based metrics. The American Medical Association (“AMA”) has long established a code of ethics that supports not only competent medical care for the general population,³ but has recently advocated for the civil rights of prisoners seeking medical treatment.⁴ Nonetheless, for the hospitalized patient in custody, several

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1. See, e.g., WORLD HEALTH ORGANIZATION, HEALTH IN PRISONS: A WHO GUIDE TO THE ESSENTIALS IN PRISON HEALTH 7–8, 33–41 (Lars Moller et al. eds., 2007) (describing the steps prisons should take to reduce health risks); Joseph E. Paris, *Why Prisoners Deserve Health Care*, 10 AMA J. ETHICS 2, 113–15 (Feb. 2008), <http://journalofethics.ama-assn.org/2008/02/msoc1-0802.html> (describing legal and ethical reasons for providing health care to prisoners).

2. ABA, STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS 150–51 (3d ed. 2007).

3. AMA, PRINCIPLES OF MEDICAL ETHICS (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>.

4. In *Fields v. Smith*, the American Medical Association (“AMA”) in an amicus brief supported the rights of prisoners to obtain hormonal replacement therapy for gender identification disorder, agreeing with the plaintiffs that to deprive them of this medical intervention would cause

legal and ethical questions arise that muddy the waters related to interactions between the prisoner, family, providers, and custodial agents.⁵

For hospital providers, the initial concern is who consents for basic treatment and procedures.⁶ For example, what if the prisoner-patient becomes critically ill? The consent question becomes more complicated for the incapacitated or mentally ill prisoner-patient often leaving hospital staff to wonder: who decides the goals of care and treatment?⁷ Staff may be caught in the middle, trying to determine if the family, the warden, or the medical director of the custodial agency has ultimate authority over the final decision regarding the patient's welfare.⁸ There are questions that must be addressed when looking at private hospitals. Are private hospitals considered state actors for constitutional liability purposes since most receive federal funding that supplies a large part of operating budgets?⁹ Does a private hospital have a role in coordinating organ donation for a prisoner-patient?¹⁰ After a brief contextual review of prisoner epidemiology, this article will explore informed consent, organ donation, and sources of liability for both public and private entities, and suggest policy parameters to guide providers who may treat prisoners.

“physical and emotional harm.” Brief for Am. Med. Ass’n, Mental Health America, et al., as Amici Curiae Supporting Appellees, *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2010) (Nos. 10-2339 & 10-2446).

5. Nancy Dubler, *Ethical Dilemmas in Prisons and Jail Health Care*, HEALTH AFFAIRS BLOG (Mar. 10, 2014), <http://healthaffairs.org/blog/2014/03/10/ethical-dilemmas-in-prison-and-jail-health-care/> (outlining various ethical issues that arise for a hospitalized prisoner, including refusal/denial of care, the doctor-patient relationship, informed consent, and confidentiality).

6. Linda Fleisher et al., *A Practical Guide to Informed Consent: What is Informed Consent?*, TEMPLE UNIV. HEALTH SYS., <http://www.templehealth.org/ICTOOLKIT/html/ictoolkitpage1.html> (last visited Sept. 30, 2015).

7. E. Fuller Torrey et al., *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, TREATMENT ADVOCACY CTR. (Apr. 8, 2014), <http://tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>.

8. See generally *Prisons and Prisoners' Rights: An Overview*, LEGAL INFORMATION INST., http://www.law.cornell.edu/wex/prisoners_rights (last visited Sept. 15, 2015) (stating that the courts generally will defer to prison officials in making decisions about prisoners' rights).

9. *Sykes v. McPhillips*, 412 F. Supp. 2d 197, 200–01 (N.D.N.Y. 2006) (stating the instances where private hospitals are state actors for constitutional purposes: (1) when there is a nexus between the state and the provider, (2) when the provider acts under state compulsion, and (3) when the provision of care constitutes a public function).

10. Cf. Andrew M. Cameron et al., *Should a Prisoner be Placed on the Organ Transplant Waiting List?*, AMA J. ETHICS (Feb. 2008), <http://journalofethics.ama-assn.org/2008/02/ccas2-0802.html> (discussing ethical and legal considerations underlying the question of whether a prisoner should be placed on the organ transplant waiting list).

II. GENERAL EPIDEMIOLOGY OF PRISONERS IN THE U.S.

In essence, the total prison population has expanded significantly over the years,¹¹ and with this expansion comes an understandably higher incidence of inmate disease requiring medical services.¹² The various jurisdictions are at liberty to determine “how” to deliver care—whether through hired prison medical staff and contractors, or sending inmates to private hospitals for specialty or emergency services.¹³ Of interest to the private provider is the expectation of being asked to see and treat a larger number of prisoners than in prior years.¹⁴ Interestingly enough, though not explored in this article, telemedicine may also be a future way in which the private provider will be asked to consult on prisoner medical matters.¹⁵

A. General Numbers of Prisoners

The National Prisoner Statistics (“NPS”) Program has operationalized the collection of annualized prisoner data through the U.S. Census Bureau since the early 20th Century,¹⁶ but participation in the survey is voluntary.¹⁷ State prisoner population totals, as of the end of 2013, far outpaced federal prisons in terms of the volume of inmates.¹⁸ Specifically,

11. See *U.S. Prison Populations – Trends and Implications*, THE SENTENCING PROJECT, <http://www.prisonpolicy.org/scans/sp/1044.pdf> (last visited Sept. 30, 2015) (stating that the number of inmates in American prisons has exceeded two million for the first time).

12. See *State Prison Health Care Spending*, A REPORT FROM THE PEW CHARITABLE TRUSTS AND THE JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION 1, 9 (July 2014), <http://www.pewtrusts.org/~media/Assets/2014/07/StatePrisonHealthCareSpendingReport.pdf> (detailing statistics regarding the prevalence of disease and mental illness in prisons).

13. See Beth Kutscher, *Rumble Over Jailhouse Healthcare*, MODERN HEALTHCARE (Aug. 31, 2013), <http://www.modernhealthcare.com/article/20130831/MAGAZINE/308319891>.

14. See Douglas C. McDonald et al., *Telemedicine Can Reduce Correctional Health Care Costs: An Evaluation of a Prison Telemedicine Network*, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, NAT’L INST. OF JUSTICE 14 (Mar. 1999), <https://www.ncjrs.gov/pdffiles1/175040.pdf> (showing almost 120 total telemedicine consultations per month in 1997 compared to 40 conventional in-prison consultations).

15. *Id.* at 29; Philip S. Schaeffer et al., *Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care*, URBAN INST. 7 (Feb. 2013), <http://www.urban.org/UploadedPDF/412754-Inmate-Health-Care.pdf> (describing how telemedicine is a way for doctors to speak to their patients remotely, and has the capacity to increase efficiency and reduce costs).

16. E. Ann Carson, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2013 (2014) [hereinafter *BJS Prisoners 2013*]. This report by E. Ann Carlson, Ph.D., is a compilation of demographic statistics, including total numbers of inmates by prison jurisdiction, male/female comparisons, sentenced prisoners, imprisonment rate per 100,000, and admissions and releases of prisoners for 2012 and 2013. The report also includes jurisdictional volume data for prisoners held in the custody of private prisons inter alia as well as a state-by-state analysis, offense data, and military correctional data.

17. *Id.* at 28.

18. *Id.* at 2.

state prisons housed 1,358,875 inmates while federal prisons housed 215,866 inmates for a total prison population of 1,574,741 in 2013.¹⁹ 2013 saw the first increase in prison population in three years by approximately 4,300 inmates.²⁰ Overall, the total number of prisoners in both federal and state facilities has risen approximately five-fold since 1978.²¹ The burden for assessing, treating, and caring for this large number of prisoners rests with state and federal governments.²² While there are several options for providing medical services to prisoners, more states are privatizing medical services through third party contractors.²³ This article does not discuss the debate over whether privatization of medical services is better or worse for patient health care. Rather, this article is concerned with prisoner-patients who are taken outside of contracted services for medical care and addresses the different sources of liability for state actors and individual physicians.

Often private hospitals are called upon as experts in specialty areas to treat prisoner-patients, including those in emergency situations.²⁴ While the NPS collects information regarding the number of prisoners who are transported to private hospitals for treatment, states furnish this information on a voluntary basis.²⁵ Thus, there is simply no way of knowing the actual volume of prisoner-patients in the private setting without an intense jurisdiction-by-jurisdiction survey utilizing cost analysis data or other coding source through state agencies.²⁶

19. *Id.*

20. *Id.*

21. *Id.* at 1.

22. John Schmitt et al., *The High Budgetary Cost of Incarceration*, CTR. FOR ECON. & POL'Y RESEARCH 10 (June 2010), <http://www.cepr.net/documents/publications/incarceration-2010-06.pdf> (stating that federal, state, and local governments combined spent almost \$75 billion on corrections in 2008).

23. See, e.g., *Innovative Correctional Healthcare*, WEXFORD HEALTH, <http://www.wexfordhealth.com/index.php> (last visited Nov. 26, 2015). Wexford Health Sources, Inc. was incorporated in 1992 for the purpose of delivering medical services to correctional facilities. They serve over 97,000 inmates in 120 correctional institutions across the country. *Id.*

24. See *Patients' Rights*, WEST'S ENCYC. OF AM. LAW, http://www.encyclopedia.com/topic/Patients_Rights.aspx (last visited Sept. 30, 2015) (discussing the Emergency Medical Treatment and Active Labor Act, passed in order to prevent "patient dumping" by setting out the criteria for emergency services and the safe transfer of patients between hospitals); see also *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) (recognizing that a private health care organization may be liable under a tort theory when the organization "knew that [specialty] medical care was necessary but simply refused to provide it").

25. *BJS Prisoners 2013*, *supra* note 16, at 28 (stating that the report's effectiveness depends on state participation).

26. *Id.* (explaining jurisdictional issues and the distinction of "inmates in custody" vs. "prisoners under jurisdiction," as well as non-reporting states that may further convolute the data the author is discussing in this article).

Even at the state level, available data is not easily acquired, and sometimes not collected at all.²⁷ In Maryland, the Health Services Cost Review Commission (“HSCRC”) sets reimbursement rates for hospitals and collects data related to admissions and discharges.²⁸ Of the hundreds of data points that are tabulated routinely by the HSCRC,²⁹ none are granular enough to demonstrate what percentage of inmates in the state utilizes private resources.³⁰ If the HSCRC is representative of available data on this topic, it is not immediately clear that prisoner use of private health systems is publicly reported.³¹ Recently published evidence suggests, however, that health care spending has increased related to the burgeoning prisoner population.³² According to a recent publication by the Pew Charitable Trusts entitled “Managing Prison Health Care,” a majority of states have seen a 28% increase in health care spending owing in part to an aging prison population with underlying diseases brought by them into the system.³³

The Maryland example, however, may provide some insight into the utilization. The Maryland Department of Public Safety and Correction Services (“DPSCS”) collects basic information on costs and volume of prisoners who utilize inpatient care, outpatient specialty and surgical care, and emergency department resources.³⁴ For fiscal year 2014 (FY14), 5,944 prisoners were seen in private settings in those categories.³⁵ In calendar year 2013 for Maryland, the total number of sentenced prisoners, state and federal, male and female, was 20,988.³⁶ Though the data collection periods

27. *Id.* at 28–29 (discussing non-reporting states).

28. *Hospital Patient Level Data Submission Requirements and Production Schedules*, THE MARYLAND HEALTH SERVICES COST REVIEW COMM’N, http://www.hsrc.state.md.us/hsp_Data.cfm (last visited Oct. 7, 2015); *Rate Setting Activities*, THE MARYLAND HEALTH SERVICES COST REVIEW COMM’N, <http://www.hsrc.state.md.us/aRates.cfm> (last visited Sept. 30, 2015).

29. See generally *Hospital Data and Reporting*, THE MARYLAND HEALTH SERVICES COST REVIEW COMM’N, http://www.hsrc.state.md.us/hsp_Data.cfm (last visited Oct. 7, 2015).

30. *Id.*

31. *Id.*

32. *Managing Prison Health Care Spending*, THE PEW CHARITABLE TRUSTS, <http://www.pewtrusts.org/en/research-and-analysis/reports/2014/05/15/managing-prison-health-care-spending> (last visited Oct. 7, 2015). The Pew Charitable Trust analysis of state-by-state prisoner health care spending showed a 28% median increase in per-inmate spending in 35 of 44 states. *Id.* The explanation for the increase includes, “Aging inmate populations[,] [p]revalence of infectious and chronic diseases, mental illness, and substance abuse among inmates, many of whom enter prison with these problems.” *Id.*

33. *Id.*

34. Email sent from The Medical Director’s Office of DPSCS, to Jeffrey Natterman (Nov. 21, 2014) (on file with author) (DPSCS contracts for utilization management).

35. *Id.*

36. *BJS Prisoners 2013*, *supra* note 16, at 5.

do not exactly correlate between the Maryland methods and the NPS systems, a general mathematical correlation suggests that approximately 28 percent of prisoners were seen and treated at private facilities in Maryland during a twelve-month period.³⁷

B. Morbidity and Mortality Data

Comparisons of prisoner mortality rates between the state, federal, and local institutions cannot be performed with clarity due to the diverse demographics and health characteristics of each jurisdiction.³⁸ However, in 2012, while the mortality rate in federal prisons declined by 10 percent, there was no substantive change in the state prison mortality rate.³⁹

In comparing the reported causes of death for local jails and state prisons, the numbers in the following table represent the statistically significant rate for each category. Note, however, that the Federal Bureau of Prisons has not released cause of death information for analysis by the Bureau of Justice Statistics.⁴⁰

TABLE 1: REPORTED CAUSES OF DEATH AT LOCAL JAILS AND STATE PRISONS

| | AGE AT DEATH | CAUSE OF DEATH | SEX |
|--------------|----------------------|---|-------------|
| LOCAL JAIL | 51% were 45 or older | Suicide 40/100,000 | Males - 87% |
| STATE PRISON | 55% were 45 or older | Cancer 81/100,000 Heart Disease 63/100,000 | Males - 97% |

37. Grossly calculating the number of private Maryland visits “x,” or 5,944, divided by the NPS data for Maryland total prisoners by calendar year “y,” or 20,988, for an estimated value of 28.3%. *Infra* notes 34–36. This number represents a significant portion of prisoner-patients in the private setting, but also is fluid because of the lack of data collection on this topic. *Id.*

38. See Margaret E. Noonan & Scott Ginder, *Mortality in Local Jails and State Prisoners, 2000-2012-Statistical Tables*, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS 3 (Oct. 2014), <http://www.bjs.gov/content/pub/pdf/mljsp0012st.pdf> [hereinafter *BJS Mortality 2012*].

39. See *id.* at 3. According to the report, there was a total of 3,351 deaths in state prisons while local jails saw the first increase in death rates by 2% in 2009. *Id.*

40. *Id.* at 28.

Whether a prisoner receives direct, hands-on care, or care over the airwaves, a major deficit in analyzing and understanding prisoner health issues is the uncoordinated methodologies for obtaining and reporting data at many levels.⁴¹ Nonetheless, the legal benchmarks by which that care is consented to and delivered are complex but readily available and digestible for the private provider.⁴²

III. CONSENT FOR HOSPITALIZED PRISONER-PATIENTS AND THE PRISON'S INTERESTS

A. *Medical Consent to Treat*

It is well-settled law that prisoners maintain constitutional protections while incarcerated.⁴³ In *Turner v. Safley*, the Supreme Court declared “[p]rison walls do not form a barrier separating prison inmates from the protections of the Constitution.”⁴⁴ It is also well-settled that such constitutional rights for prisoners are not absolute, and that great deference should be given to state actors in making and implementing policies that are aimed at maintaining the safety and security of the institution.⁴⁵ Finding the balance between a prisoner’s constitutional rights while incarcerated and a state actor’s policy determinations can be a challenge, especially in the context of providing health care to prisoners.⁴⁶

In the watershed case *Estelle v. Gamble*, the Supreme Court determined that the Eighth Amendment to the Constitution provides that

41. Schaenman et al., *supra* note 15, at 28.

42. See *Prisons and Prisoners' Rights: An Overview*, LEGAL INFORMATION INST., http://www.law.cornell.edu/wex/prisoners_rights (last visited Sept. 30, 2015).

43. *Id.*

44. *Turner v. Safley*, 482 U.S. 78, 84 (1987).

45. See *Overton v. Bazzetta*, 539 U.S. 126, 132 (2003) (“We must accord substantial deference to the professional judgment of prison administrators, who bear a significant responsibility for defining the legitimate goals of a corrections system and for determining the most appropriate means to accomplish them.”); see also *O’Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987) (“To ensure that courts afford appropriate deference to prison officials, we have determined that prison regulations alleged to infringe constitutional rights are judged under a ‘reasonableness’ test less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights.”); *Turner*, 482 U.S. at 85 (“Where a state penal system is involved, federal courts have, as we indicated in *Martinez*, additional reason to accord deference to the appropriate prison authorities.”); *Procunier v. Martinez*, 416 U.S. 396, 405 (1973) (“where state penal institutions are involved, federal courts have a further reason for deference to the appropriate prison authorities.”).

46. *Pabon v. Wright*, 459 F.3d 241, 252 (2d Cir. 2006) (holding that if prison officials, including doctors, identify situations in which they reasonably believe that treatment is required, notwithstanding the prisoner’s asserted right to refuse it, the right must give way).

prisoners are entitled to adequate health care while incarcerated.⁴⁷ The Court concluded that “deliberate indifference to serious medical needs of prisoners” meets the level of cruel and unusual punishment proscribed by the Eighth Amendment.⁴⁸ A prisoner, by definition, is not free to seek treatment for serious medical conditions that may be life-threatening or extremely painful.⁴⁹ Allowing a prisoner to suffer with a treatable medical condition that the prisoner cannot address on his own due to confinement imposed by the state could result in liability for the state under the Eighth Amendment.⁵⁰

The standard for determining “deliberate indifference,” and thus the fundamental constraints on state-provided health care in prison, was established in *Farmer v. Brennan*.⁵¹ There, the Supreme Court held that in order for an official to be found liable for cruel and unusual punishment under the Eighth Amendment for denying health care, the health care official must both be aware of an excessive risk to the inmate’s health or safety and must disregard such risk.⁵² “The Eighth Amendment does not outlaw cruel and unusual ‘conditions’; it outlaws cruel and unusual ‘punishments.’”⁵³ The showing of deliberate indifference must be subjective and based on the intent of the actor.⁵⁴

While a prisoner’s right to receive health care is embedded within the United States Constitution’s Eighth Amendment,⁵⁵ a prisoner’s right to consent to or refuse such health care is mostly embedded in the common-law right to informed consent and an individual’s constitutional right to privacy.⁵⁶ Generally, courts have permitted prisoners to exercise this right

47. *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976) (holding that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ proscribed by the Eighth Amendment”).

48. *Id.* at 104.

49. *ABA Criminal Justice Standards on the Treatment of Prisoners*, 102–03 (3d ed. 2011), http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/treatment_of_prisoners_commentary_website.pdf.

50. Brittany Bondurant, *The Privatization of Prisons and Prisoner Healthcare: Addressing the Extent of Prisoners’ Right to Healthcare*, 39 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 407, 408–09 (2013). *See also* *West v. Atkins*, 487 U.S. 42, 50–51 (1988) (holding that there was state action where a private physician had contracted with the state to provide medical care for prisoners).

51. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

52. *Id.*

53. *Id.*

54. *See id.* (stating that the official must be aware of facts from which he or she could infer a substantial risk of serious harm, and he or she must also draw the inference).

55. *Id.* at 832.

56. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 271 (1990) (“After *Quinlan*, however, most courts have based a right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right.”).

to consent to treatment or refuse to receive treatment in the same way any patient outside of the prison system would be permitted to do so.⁵⁷ The exception to such standard is when the state's interest outweighs the liberty interest of the patient in making his or her medical decisions.⁵⁸ As stated above, prisoners continue to enjoy the protections of the Constitution even while incarcerated, but the Court has determined that many of the protections afforded to other citizens do not extend, in full, to prisoners.⁵⁹ As the Court in *Washington v. Harper* stated, "the extent of a prisoner's right under the [Constitution] to avoid the unwanted [treatment] must be defined in the context of the inmate's confinement."⁶⁰

The Supreme Court set the standard in *Turner* by which a court should determine whether a state action unconstitutionally impinges on an inmate's constitutional right, such as a prisoner's right to privacy in making his or her own health care decision that may conflict with the prison's interest.⁶¹ The standard is whether the action is "reasonably related to a legitimate penological interest."⁶² The Court articulated the standard largely on the principle of separation of powers by noting, "[s]ubjecting the day-to-day judgments of prison officials to an inflexible strict scrutiny analysis would seriously hamper their ability to anticipate security problems and to adopt innovative solutions to the intractable problems of prison administration."⁶³ The Court further noted that "[T]he rule would also distort the decision-making process, for every administrative judgment would be subject to the

57. See, e.g., *id.* at 278 ("Just this Term, in the course of holding that a State's procedures for administering antipsychotic medication to prisoners were sufficient to satisfy due process concerns, we recognized that prisoners possess 'a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.'") (quoting *Washington v. Harper*, 494 U.S. 210, 221–22 (1990)); *Harper*, 494 U.S. at 229 ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"); *Pabon v. Wright*, 459 F.3d 241, 250 (2d Cir. 2006); *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990) ("A prisoner's right to refuse treatment is useless without knowledge of the proposed treatment. Prisoners have a right to such information as is reasonably necessary to make an informed decision to accept or reject proposed treatment, as well as a reasonable explanation of the viable alternative treatments that can be made available in a prison setting."); *Leaphart v. Prison Health Servs.*, No. 3:10-CV-1019, 2010 U.S. Dist. LEXIS 135435 (M.D. Pa., Dec. 21, 2010) (holding that convicted prisoners retain a limited right to refuse treatment and a related right to be informed of the proposed treatment and viable alternatives).

58. See *Prisons and Prisoners' Rights: An Overview*, LEGAL INFORMATION INST., http://www.law.cornell.edu/wex/prisoners_rights (last visited Oct. 8, 2015) (stating that the rational basis test is used to review prison regulations).

59. *Overton v. Bazzetta*, 539 U.S. 126, 131 (2003) (noting that freedom of association is curtailed in the prison context).

60. *Harper*, 494 U.S. at 222.

61. *Turner v. Safley*, 482 U.S. 78, 84, 89 (1987).

62. *Id.* at 89.

63. *Id.*

possibility that some court somewhere would conclude that it had a less restrictive way of solving the problem at hand.”⁶⁴

The Court in *Turner* set forth four factors that should be taken into consideration when determining whether a state action by prisons meets the rational basis test: (1) whether there is a “valid, rational connection” between the state action and a legitimate government interest, (2) whether alternative means exist for those impacted to exercise the asserted constitutional right, (3) whether and to what extent accommodating the asserted right will impact prison staff, the inmates’ liberty, and the distribution of resources, and (4) whether alternatives exist that are less restrictive and still achieve the asserted interests of the state.⁶⁵

Great deference is afforded to prison officials in determining what is necessary for the security and safety of the prison and the other prisoners,⁶⁶ and “it is the rare case in which a court finds that the State’s intrusion into the constitutional rights of a presumptively innocent criminal defendant warrants a judicial intrusion into ‘the determinations of those charged with the formidable task of running a prison.’”⁶⁷

The Supreme Court elaborated upon its decision in *Turner* when holding, in *Harper*, that a prison official’s ability to override a patient’s health care decision-making stands even if the patient is incompetent.⁶⁸ In applying the standard articulated in *Turner*, the Supreme Court concluded that a prison’s action to medicate an incompetent, violent prisoner who represents a danger to prison officials and others within the prison walls was “reasonably related to a legitimate penological interest,”⁶⁹ and that such a rational basis standard should be applied even if the constitutional right being infringed is fundamental.⁷⁰ The fact that the prisoner was incompetent did not change the Court’s analysis.⁷¹ Courts applying *Turner* have concluded that there are many other scenarios in which the state’s interest is reasonably related to a legitimate penological objective, thus validating infringement on a prisoner’s constitutional right to privacy and, by extension, a prisoner’s right to consent to or refuse medical treatment the

64. *Id.*

65. *Id.* at 89–91.

66. *Id.* at 85.

67. Jason Feldman, *Piercing the Veil of Dangerousness in Forcible Medication: Why Pretrial Detainees Are Due More Process Than* *Washington v. Harper*, 63 SYRACUSE L. REV. 467, 491 (2013) (quoting *O’Lone v. Estate of Shabazz*, 482 U.S. 342, 353 (1987)).

68. *Washington v. Harper*, 494 U.S. 210, 222–23 (1990).

69. *Id.* at 225–26.

70. *Id.* at 223.

71. *Id.* at 222.

prison officials believe is in the prison's best interest.⁷² For example, the Supreme Judicial Court of Massachusetts in 1979 held that a prisoner could be forced to undergo dialysis because the prisoner's refusal to undergo dialysis was not related to his wish to die, but rather was an act of protest in an attempt to secure a transfer to a minimum security prison.⁷³ The court determined that it would be too disruptive to the prison system to have patients refuse medical treatment in an attempt to manipulate prison officials and held that that state's interest in maintaining the order of the prison overrode the prisoner's constitutional right of privacy and choice of health care.⁷⁴

The District Court for the Southern District of New York reached the same conclusion in *Zaire v. Dalsheim*, where a prisoner was required to receive the diphtheria-tetanus vaccine or face solitary confinement.⁷⁵ The court concluded that the state's interest in "preventing the spread of deadly diseases among a closely quartered prison population"⁷⁶ overrode any interest an individual prisoner may have in refusing the inoculation, since it was reasonably related to a legitimate penological objective.⁷⁷

B. Constitutional Rights of Incompetent or Incapacitated Prisoners

It appears relatively settled law that a competent prisoner has the right to consent to or refuse to receive medical treatment, and that a prison official may either override such a decision or force treatment on the prisoner provided there is a legitimate penological interest being served.⁷⁸ However, the jurisprudence fails to address who stands in the shoes of the patient in making medical decisions when the patient is incapacitated or incompetent and there is no legitimate danger or fear with which the prison

72. *Comm'n of Corr. v. Myers*, 399 N.E.2d 452, 458 (Mass. 1979); *Zaire v. Dalsheim*, 698 F. Supp. 57, 59 (S.D.N.Y. 1988), *aff'd* 904 F.2d 33 (2d Cir. 1990).

73. *Myers*, 399 N.E.2d at 458.

74. *Id.*

75. *Zaire*, 698 F. Supp. at 58, 60–61.

76. *Id.* at 60.

77. *Id.*

78. *Prisons and Prisoner's Rights: An Overview*, LEGAL INFORMATION INST., http://www.law.cornell.edu/wex/prisoners_rights (last visited Sept. 15, 2015). *See also* *Turner v. Safley*, 482 U.S. 78, 89 (1987) (stating that "when a prisoner regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests").

officials are concerned.⁷⁹ The answer to such question often lies within individual state statutes.⁸⁰

Almost all states have a mechanism that permits individuals to designate a health care agent who is responsible for making medical decisions for the individual in the event the individual becomes incapacitated or incompetent.⁸¹ States also promulgate laws that establish a “default” hierarchy of decision-makers in the event the patient has not properly identified who he or she wants to be the decision maker.⁸² Most states do not directly address the issue of the prisoner-patient. Absent statutory instructions to the contrary, hospitals should rely upon the state sanctioned hierarchy of decision makers when faced with a prisoner who is incapacitated or incompetent.⁸³

While one could argue that prisoners are wards of the state, and therefore, it is the state that should make health care decisions on behalf of the incapacitated or incompetent patient, the interest of the patient rarely aligns with the interest of the prison.⁸⁴ Absent a legitimate state interest to the contrary, prison officials should be removed from the medical decision-making process, as the patient’s surrogate would likely best represent the patient’s interests.⁸⁵ To select a surrogate, the typical statutory hierarchy should be followed, as the hierarchy reflects those in the best position to carry out the patient’s wishes.⁸⁶

The State of Maryland Department of Public Safety and Correctional Services (“DPSCS”) developed a policy that directly addresses medical decision making for incompetent inmates and has implemented a process

79. See generally Women’s Health & Education Center, *End of Life Decision Making*, <http://www.womenshealthsection.com/content/print.php3?title=heal022&cat=5&lng=english> (last visited Oct. 15, 2015).

80. *Id.* See also ABA, *Default Surrogate Consent Statutes* (June 2014), www.americanbar.org/content/dam/aba/administrative/law_aging/2014_default_surrogate_consent_statutes.authcheckdam.pdf (providing an overview of state default surrogate consent statutes in the absence of an appointed agent or guardian with health powers).

81. *Id.*

82. ABA, *Standards for Criminal Justice: Treatment of Prisoners*, http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-1.1 (2011).

83. *Id.*

84. See M. Scott Smith et al., *Healthcare Decision-Making for Mentally Incapacitatedarcerated Individuals*, 22 ELDER L.J. 175, 197–98 (2014).

85. *Id.* at 198 (noting that the patient’s surrogate is often in the best position to make the decisions in the patient’s best interests).

86. *Id.* See also ABA, *Standards on Treatment of Prisoners*, § 23-6.14, http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-6.14.

requiring judicial review.⁸⁷ Policy #124-403 states: “it is the policy of DPSCS to allow inmates to accept or refuse medical/mental health treatment up to the degree of their competency.”⁸⁸ Further, “[f]or individuals determined to be incompetent, however, guardianship in some form may have to be secured.”⁸⁹ The policy proscribes that once evaluated and deemed incompetent by a psychiatrist assigned by the private medical provider contracted to provide services at the institution where the inmate is housed, guardianship should be pursued for the inmate.⁹⁰

In Maryland, guardianship proceedings require a conclusion from a court of competent jurisdiction that there is

clear and convincing evidence that a person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including provisions for health care . . . because of any mental disability [or] disease . . . and that no less restrictive form of intervention is available which is consistent with the person’s welfare and safety.⁹¹

The guardianship proceeding inherently involves appointing an independent third party who is most likely to adhere to the standard of substituted judgment, and choose the course of action most similar to the patient had the patient not been incapacitated.⁹² Interestingly, for the Maryland general population, the law does not require a psychiatrist or psychologist to determine incapacity, but only requires two licensed physicians.⁹³ The Maryland DPSCS has clearly prescribed an added layer of protection for the potentially incapacitated prisoner needing health care.⁹⁴ A surrogate structure such as this could serve as a model policy in most jurisdictions to ensure the prisoner-patient’s best interest is represented in complicated medical decision-making scenarios. While such

87. STATE OF MD. DEP’T. OF PUB. SAFETY & CORR. SERVS., *Petition for Guardianship*, https://www.dpccs.state.md.us/publicservs/procurement/ihs/directives/DOC/124_403.pdf (last visited Oct. 1, 2015).

88. *Id.*

89. *Id.*

90. *Id.*

91. MD. CODE ANN., EST. & TRUSTS § 13-705(b) (LexisNexis 2014).

92. *Id.*

93. MD. CODE ANN., HEALTH-GEN. § 5-606(a)(1) (LexisNexis 2009) (“Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment.”).

94. MD. PUB. SAFETY & CORR. SERVS., *Petition for Guardianship*, DPSCSD 124-403, https://www.dpccs.state.md.us/publicservs/procurement/ihs/directives/DOC/124_403.pdf (last visited Oct. 1, 2015).

a policy is likely in the patient's best interest,⁹⁵ absent clear legal guidance or local policy, the liability risks hospitals face in permitting such surrogate decision making remain unclear.

C. Prisoners and Organ Donation

Issues abound when considering prisoner organ donation.⁹⁶ These range from the ethical concerns about whether a prisoner should receive valuable organ resources over the general population to whether death row inmates should be allowed to donate their organs upon successful executions.⁹⁷ The opinions are both varied and persuasive depending on your core ethical and medico-legal beliefs.⁹⁸ This paper does not explore the heated ethical debates regarding prisoners and organ transplant. Instead, it focuses on providing guidance on the operational aspects of prisoner organ donation for private hospitals.

The Organ Procurement and Transplant Network ("OPTN") was established by Congress thirty years ago to proscribe the selling of organs, and to coordinate and control this scarce resource allocation.⁹⁹ OPTN has established clear policies with regard to every facet of the organ donation process.¹⁰⁰ However, Organ Procurement Organizations ("OPO") are free to set their own criteria for accepting organs and the prisoner population may be excluded from consideration under these policies.¹⁰¹ The OPTN policies establish the responsibility for determining organ compatibility and

95. *End of Life Decision Making*, WOMEN'S HEALTH & EDUCATION CTR., <http://www.womenshealthsection.com/content/print.php3?title=heal022&cat=5&lng=english> (last visited Oct. 1, 2015).

96. See, e.g., *Should Prisoners be Allowed to Donate their Organs?*, N.Y. TIMES, <http://www.nytimes.com/roomfordebate/2013/04/25/should-prisoners-be-allowed-to-donate-their-organs> (last updated Apr. 26, 2013).

97. Whitney Hinkle, *Giving Until it Hurts: Prisoners are not the Answer to the National Organ Shortage*, 35 IND. L. REV. 593, 596–97, 601–02 (2002); Kate Douglas, *Prison Inmates are Constitutionally Entitled to Organ Transplants – So Now What?*, 49 ST. LOUIS U. L.J. 539, 561–62 (2005); Arkalgud Sampath Kumar, *Prisoners on Death Row*, 95 ANN THORAC 770, 770 (2013), <http://www.annalsthoracicsurgery.org/issue/S0003-4975%2812%29X0013-4?page=1>; M.A. Millis & M. Simmerling, *Prisoners as Organ Donors: Is it Worth the Effort? Is it Ethical?*, 41 TRANSPLANTATION PROC. 1, 23–24 (2009); OPTN/UNOS Ethics Comm., *The Ethics of Organ Donation from Condemned Prisoners*, <http://optn.transplant.hrsa.gov/resources/ethics/the-ethics-of-organ-donation-from-condemned-prisoners/> (last visited Oct. 1, 2015).

98. See Hinkle, *supra* note 97; see also Kumar, *supra* note 97.

99. NATIONAL ORGAN TRANSPLANT ACT OF 1984, 42 U.S.C. § 274e (2006); Blood Vessels Recovered with Organs and Intended for use in Organ Transplantation, 71 Fed. Reg. 27649 (proposed May 12, 2006) (to be codified at 42 C.F.R. pt. 121).

100. *Organ Procurement and Transplantation Network Policies*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (last visited Oct. 1, 2015), http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Policies.pdf [hereinafter *OPTN Policies*].

101. *Id.*

candidacy on OPO.¹⁰² However, what is clear from the point of view of the Ethics Committee of the OPTN/United Organ Sharing Network (“UNOS”) is that prisoners should not be excluded from lists of those seeking organs simply because they are incarcerated.¹⁰³ Specifically, “[t]he UNOS Ethics Committee opines that absent any societal imperative, one’s status as a prisoner should not preclude them from consideration for a transplant; such consideration does not guarantee transplantation.”¹⁰⁴

Essentially, a prisoner is ethically entitled to receive a transplanted organ like anyone else on a transplant list and will be required to meet the strict criteria established to be a successful candidate.¹⁰⁵ Once the medical provider for the correctional facility has identified a prisoner as needing an organ transplant, the prisoner would be referred to a transplant center for medical work up and a determination of candidacy.¹⁰⁶ The transplant center then would follow its own specific policies regarding prisoner categorization and candidacy.¹⁰⁷

There is some recent evidence that facilitating prisoners’ access to organ transplants would actually reduce penological costs.¹⁰⁸ In a study conducted evaluating 104 incarcerated end-stage renal disease (“ESRD”) patients, nine patients with a history of Hepatitis C were transplanted faster with Hepatitis C kidneys than other prisoners waiting for non-infectious organs (6.6 months versus 49.6 months).¹⁰⁹ Study investigators concluded that overall costs for managing post-transplant patients were substantially lower than costs for continuing dialysis for those still waiting for kidneys.¹¹⁰

102. *Id.*

103. *Organ Procurement and Transplantation Network Convicted Criminals and Transplant Evaluation*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (last visited Oct. 1, 2015), <http://optn.transplant.hrsa.gov/resources/ethics/convicted-criminals-and-transplant-evaluation/>.

104. *Id.*

105. See OPTN/UNOS Ethics Committee, *The Ethics of Organ Donation from Condemned Prisoners*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (last visited Oct. 1, 2015), <http://optn.transplant.hrsa.gov/resources/ethics/the-ethics-of-organ-donation-from-condemned-prisoners/> (stating, however, that the “OPTN/UNOS Ethics committee opposes any strategy or proposed statute regarding organ donation from condemned prisoners until all of the potential ethical concerns have been satisfactorily addressed.”); see also United Network for Organ Sharing, *What Every Patient Needs to Know* (last visited Oct. 1, 2015), <http://www.unos.org/docs/WEPNTK.pdf> (explaining the purpose of the United Network for Organ Sharing and its mission of availability for all types of patients).

106. *Id.* at 7.

107. *Id.*

108. See Mandip Panesar et al., *Evaluation of a Renal Transplant Program for Incarcerated ESRD Patients*, 20 J. CORRECTIONAL HEALTH CARE 220, 226 (2014) (addressing the significant benefits of allowing prisoners’ access to transplants as opposed to dialysis).

109. *Id.*

110. *Id.*

Private transplant centers engage in debates that focus more on their business model and institutional guidelines rather than constitutional or ethical concerns.¹¹¹ These centers are pressed to discern available organs in constant demand,¹¹² and to pass national certification muster with regard to survival rates, among other criteria.¹¹³ Prisoners who come to the hospital with a higher morbidity rate than the general population are not routinely considered the best candidates to either donate or to receive organs.

Succinctly, in the absence of federal guiding documents or laws on prisoner organ donation, such policies and procedures are established state by state.¹¹⁴ As an example, Maryland's Department of Public Safety and Correctional Services articulates the necessary procedures for those prisoners seeking transplantation, either to receive or donate.¹¹⁵ In Maryland, prisoners may donate organs to a family member in state, but the policy does not allow them to receive a solid organ.¹¹⁶ The donation process is overseen by the prison system's regional medical director, but is clinically managed by the transplant center.¹¹⁷ The recipient bears the cost of the transplant.¹¹⁸

For prisoner-patients who are incapacitated and are admitted to private hospitals with a fatal prognosis, the question may arise as to whom would consent for an organ donation.¹¹⁹ As discussed above, the consent process would typically follow the state statutes and regulations for surrogate decision making.¹²⁰ The correctional facility could release the prisoner-patient from incarceration as their continued custody requirement cannot be accomplished for punishment or rehabilitation owing to their fatal condition. At that point, the prisoner-patient simply would become like any

111. Hinkle, *supra* note 98.

112. *Id.* at 593–94.

113. See U.S. DEP'T OF HEALTH & HUMAN SERV., ADVISORY COMM. ON ORGAN TRANSPLANTATION (2011) (noting regulations that encourage an increased rate of organ transplants from all types of donors and stringent transplant requirements in order to meet certification standards).

114. *Prisoner Organ Transplants, Donations Create Controversy*, PRISON LEGAL NEWS (Apr. 15, 2014), <https://www.prisonlegalnews.org/news/2014/apr/15/prisoner-organ-transplants-donations-create-controversy/> (highlighting numerous states and their various approaches regarding prisoner organ donation).

115. MD. DEP'T OF PUB. SAFETY AND CORR. SERV. OFFICE OF CLINICAL SERV. AND INMATE HEALTH, ADMINISTRATIVE MANUAL, CH. 12, ORGAN DONORS AND TRANSPLANTS.

116. *Id.* at 1.

117. *Id.* at 2–3.

118. *Id.*

119. *The Ethics of Organ Donation from Condemned Prisoners*, DEP'T OF HEALTH & HUMAN SERVS. – HEALTH RES. AND SERVS. ADMIN., <http://optn.transplant.hrsa.gov/resources/ethics/the-ethics-of-organ-donation-from-condemned-prisoners/> (last visited Oct. 8, 2015).

120. Lisa V. Brock & Anna Mastroianni, *Clinical Ethics and Law*, UNIV. OF WASH. SCH. OF MED. (Jan. 22, 2013), <https://depts.washington.edu/bioethx/topics/law.html#Surrogate>.

other patient in the general population, and corresponding policies would apply.

IV. PRIVATE HOSPITAL LIABILITY

In the context of receiving health care, prisoners may seek relief for alleged damages through various avenues against both the state and private actors.¹²¹ They may pursue an action based on Constitutional or federal statutory grounds, potentially reaching the state through the Fourteenth Amendment.¹²² They may also seek relief against individual physicians by filing malpractice claims based on state guidelines.¹²³ For private hospitals, as articulated below, liability exposure exists, but a successful claim is generally atypical.¹²⁴ Notably, a successful constitutionally based claim may have a greater impact on a larger number of people as a result of changes to the law affecting all prisoners.¹²⁵ Private claims based on medical malpractice, while potentially financially rewarding for the individual, would have an insignificant impact, if any, on changing precedent.¹²⁶

A. *Constitutional and 42 U.S.C. § 1983 Claims*

The Constitution proscribes violations of prisoners' rights by the federal government through various amendments including, but not limited to, the Eighth Amendment's "cruel and unusual punishment" proscription, and by the state government through the Fourteenth Amendment.¹²⁷ The general statutory remedy for prisoners who allege violations while in custody is established in 42 U.S.C. § 1983.¹²⁸ In order for a claim to

121. *Civil Liability for Inadequate Prisoner Medical Care*, AELE MONTHLY L.J. 301, 302–03, 307 (2007), <http://www.aele.org/law/2007JBSEP/2007-09MLJ301.pdf>.

122. *Washington v. Harper*, 494 U.S. 210, 221–22 (1990).

123. *Civil Liability for Inadequate Prisoner Medical Care*, AELE MONTHLY L.J. 301, 302–03, 307 (2007), <http://www.aele.org/law/2007JBSEP/2007-09MLJ301.pdf>.

124. *Id.* at 301–03.

125. *Id.* at 301–02.

126. *Id.* at 301–10 (noting various cases that demonstrate the difficulty in convincing a court of both the severity of the situation and intentional disregard for the prisoner's health).

127. U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted. . ."); U.S. CONST. amend. XIV ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.")

128. 42 U.S.C. § 1983 (2012) ("Every person who, under color of any statute, ordinance, regulation, custom or usage, of any state or territory or the District of Columbia, subjects, or causes to be subjected, and citizen of the United States or other person within the jurisdiction thereof to the deprivation of any right, privileges, or immunities secured by the Constitution and

successfully move forward pursuant to the constitutional and statutory framework, the injured party must show that the defendant is a state actor, or that they have committed acts under color of state law.¹²⁹ The Supreme Court held firm to prior decisions stating that “state action” remedies and those “under color of state law” in essence are one and the same in general, though the merits giving rise to, and support of, a justiciable claim may vary from case to case.¹³⁰ Either the state acts by abridging rights, or a private person acts under the ambit of state authority who then becomes potentially liable.¹³¹ The question that remains is whether a private hospital becomes a state actor based solely on the fact that it treats prisoners within its facility.

The Supreme Court in *Lugar v. Edmondson Oil Co., Inc.*, articulated a two part approach to identify when conduct would be “fairly attributable” to the state:

First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State . . . or by a person for whom the State is responsible . . . Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor. This may be because he is a state official, because he has acted together with or has obtained significant aid from state officials, or because his conduct is otherwise chargeable to the State. *Without a limit such as this, private parties could face constitutional litigation whenever they seek to rely on some state rule governing their interactions with the community surrounding them.*¹³²

Clearly, the Court intended to limit private parties from being exposed to liability on state action grounds except where there is a clear nexus between the state and the private person.¹³³ Because the facts of each case may be distinct with regard to when a private party acts under color of state law, the Court has articulated over the years several tests to ascertain the

laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . .”).

129. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 928 (1982). The complainant filed a 42 U.S.C. § 1983 claim alleging due process violations by defendant when his property was attached pursuant to state law, thereby making a § 1983 remedy available. *Id.* at 925. The Court in *Lugar* explained the distinctions between a Fourteenth Amendment claim asserting “state action” versus a § 1983 claim asserting that a private individual acted under “color of state law.” *Id.* at 934.

130. *Id.* at 935 (“If the challenged conduct of respondents constitutes state action as delimited by our prior decisions, then that conduct was also action under color of state law and will support a suit under § 1983.”).

131. *Id.* at 935–37.

132. *Id.* at 937 (emphasis added).

133. *Id.*

connection between the private party and the state.¹³⁴ Discerning the nexus that gives rise to liability then becomes heavily fact-based.¹³⁵

Are private hospitals and providers state actors? As described below, the courts have not been clear as to whether liability attaches, and that determination is fact-dependent. As far back as 1968, the U.S. Court of Appeals for the Sixth Circuit in *Meredith v. Allen County War Memorial Hospital Commission*, held that the defendant physicians sitting on a county appointed commission were liable under color of state law.¹³⁶ The court stated:

Defendant commission members were appointed by the governing body of Allen County to operate the hospital. Moreover, the hospital is the only one in the area and was financed in part by public funds. An institution such as this, serving an important public function and financed by public funds, is sufficiently linked with the state for its acts to be subject to the limitations of the Fourteenth Amendment. Because the members of the commission hold office as a result of governmental appointment and because they administer a public facility, their actions must be regarded as having been taken under color of law. Hence, the provisions of § 1983 and § 1985(3) are applicable to them.¹³⁷

Simply put, the physicians sitting as commissioners with approval power over other physicians' employment were so connected by way of appointment, funding, and function that they were acting on behalf of the municipality, thereby making them liable under color of state law.¹³⁸ They

134. *Id.* at 939 (noting *Terry v. Adams*, 345 U.S. 461, 469–70 (the “public function” test); *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 170–71 (the “state compulsion” test); *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (the “nexus” test); *Flagg Brothers, Inc. v. Brooks*, 436 U.S. 149, 164 (the “joint action” test)).

135. *See* *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722 (1961) (involving a claim of racial discrimination by a coffee shop in a building owned by Parking Authority in which the court stated, “[o]nly by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance”); *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974) (involving plaintiff’s allegation of state action when private company cut off power without due process, the Court stated in dicta, “[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment”) (citation omitted).

136. 397 F.2d 33, 35 (6th Cir. 1968).

137. *Id.* *See also* 42 U.S.C. § 1985(3) (2006) (“[I]f two or more persons in any State or Territory conspire . . . for the purpose of depriving, either directly or indirectly, any person or class of persons of the equal protection of the laws, or of equal privileges and immunities under the laws . . . whereby another is injured in his person or property, or deprived of having and exercising any right or privilege of a citizen of the United States, the party so injured or deprived may have an action for the recovery of damages, occasioned by such injury or deprivation, against any one or more of the conspirators.”).

138. *Meredith*, 397 F.2d at 35.

were not state officials per se, but they acted as such, conspiring with state officials to deprive the plaintiffs of their rights.¹³⁹

Likewise, in *O'Neill v. Grayson County War Memorial Hospital*, the Sixth Circuit also found a sufficient nexus between the defendant hospital's Board of Directors and the state to overturn the District Court's dismissal below.¹⁴⁰ Unlike *Meredith*, the Board of Directors for Grayson County War Memorial Hospital was not appointed by the state.¹⁴¹ The *O'Neill* court found a nexus on other grounds because of other connections the hospital had with the state, including lease arrangements and hospital revenue through statutory-based allocation of funds.¹⁴² Interestingly, the *O'Neill* court did not clearly define the test upon which it relied to determine the nexus between private and state action.¹⁴³ Judicial history is replete with attempts at creating a nexus test without uniformity or universal adoption.

Closer to the point of private actors and prisoners, the Supreme Court in *West v. Adkins* explored a case involving a North Carolina inmate.¹⁴⁴ After tearing his Achilles tendon, he was assessed and treated by a contractual orthopedic physician.¹⁴⁵ The prisoner brought the § 1983 claim pro se, alleging the physician failed to adequately treat (or make a referral for) his condition through surgery.¹⁴⁶ The District Court found that the physician was acting under color of state law, and was therefore liable for damages caused by the treatment delay.¹⁴⁷ After the U.S. Court of Appeals for the Fourth Circuit vacated the District Court's decision, an *en banc* panel reheard the case and ultimately affirmed the District Court's grant of summary judgment.¹⁴⁸ The Supreme Court reversed the appellate court.¹⁴⁹ According to the Supreme Court, the split Court of Appeals erroneously

139. *Id.* at 35–36.

140. *O'Neill v. Grayson Cnty. War Mem'l Hosp.*, 472 F.2d 1140, 1142 (6th Cir. 1973) (physician plaintiff claimed his due process and equal protection rights were violated by the Board's refusal to allow him to admit patients to the hospital).

141. *Id.* at 1143.

142. *Id.* at 1142–43.

143. *Id.* The *O'Neill* Court stated, “We do not suggest that the presence of state action in this case or in any case can be determined by the application of some clear-cut test. *Id.* at 1143. *See also id.* (citing *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722 (1961) (“[T]o fashion and apply a precise formula for recognition of state responsibility under the Equal Protection Clause is an ‘impossible task’ which ‘[t]his Court has never attempted’ Only by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance.”) (citation omitted).

144. *West v. Adkins*, 487 U.S. 42, 44 (1988).

145. *Id.* at 43–44.

146. *Id.* at 44–45.

147. *Id.* at 45–46.

148. *Id.* at 46.

149. *Id.* at 57–58.

applied a prior Supreme Court decision involving an accused public defender who was found not to be acting under color of state law, and therefore not liable in a § 1983 claim.¹⁵⁰

In *West*, the respondent physician was employed under contract in order to render required medical services to inmates.¹⁵¹ Because his duties were aligned with the state's objectives, the Court held that the physician was acting under color of state law.¹⁵² The nexus was as close as it could get.¹⁵³ The state prison system had a duty to render appropriate medical care,¹⁵⁴ and the contract physician likewise had the same affirmative duty;¹⁵⁵ they were inextricably intertwined as actors with the same purpose of treating the prisoner-patient.¹⁵⁶

The Court also expressed concern that if private physicians under contract with the state are to provide medical care, they could escape liability under the pretense that they were not state actors.¹⁵⁷ Thus the state would be able to absolve itself of its constitutional duty to provide adequate medical treatment by contracting such services to a private third party.¹⁵⁸ With finality, the Court held that a successful petitioner must demonstrate two things. The first element required a showing that the petitioner was deprived a right afforded by the Constitution, or a United States law.¹⁵⁹ The second element required a showing that the offender was acting under color of law.¹⁶⁰ In this case, the physician's action satisfied both elements.¹⁶¹

At the same time, there are a host of cases where courts found no state action against a private hospital.¹⁶² The U.S. Court of Appeals for the Ninth

150. *West v. Adkins*, 487 U.S. 42, 50–51 (1988). In *Polk County v. Dodson*, the Court held that a public defender acting in his professional capacity was doing so in controversion of the state's goals in prosecuting the inmate, and therefore, was not acting under color of state law. 454 U.S. 312, 325 (1981) (opposing purposes widens the gap when determining whether or not a private actor is operating under color of state law).

151. *West*, 487 U.S. at 45.

152. *Id.* at 54–55 (stating “[i]t is only those physicians authorized by the State to whom the inmate may turn. Under state law, the only medical care West could receive for his injury was that provided by the State”).

153. *See id.* at 55 (stating that North Carolina employs physicians and defers to their professional judgment in providing medical care to its prison inmates).

154. *Id.* at 56.

155. *Id.*

156. *Id.*

157. *West*, 487 U.S. at 55–56.

158. *Id.* at 56 n.14 (quoting *West v. Atkins*, 815 F.2d 993, 998 (4th Cir. 1987)).

159. *Id.* at 48.

160. *Id.*

161. *Id.* at 48, 54.

162. *See, e.g., Watkins v. Mercy Med. Ctr.*, 520 F.2d 894, 895–96 (9th Cir. 1975) (holding that “for a state involvement with a private entity to confer jurisdiction under 42 U.S.C. § 1983 the involvement must be with the specific activity of which a party complains”) (citation omitted);

Circuit held that simply because a hospital receives federal funds, the decision not to renew a provider's privileges does not rise to the level of state action.¹⁶³ In *Watkins v. Mercy Medical Center*, a Catholic Church affiliated hospital refused a provider's renewal of privileges because he performed sterilizations and abortions against hospital bylaws.¹⁶⁴ The district court held there was no state action, and therefore, no relief under § 1983; however, they did find that the hospital was in violation of 42 U.S.C. § 300a-7.¹⁶⁵ The Court of Appeals for the Ninth Circuit affirmed, "concluding that the receipt of federal funds alone does not transform an otherwise private activity into a state action."¹⁶⁶

That same month, the Court of Appeals for the Ninth Circuit tackled a similar issue in *Taylor v. St. Vincent's Hospital*.¹⁶⁷ In *Taylor*, the hospital received state tax exemptions and Hill-Burton Funds¹⁶⁸ and denied the petitioner's request for a tubal ligation following her Caesarian section.¹⁶⁹ After the hospital refused her procedure, the patient subsequently joined a class that claimed, *inter alia*, that the hospital acted under color of state law to deny them the procedure and relief was therefore available pursuant to § 1983.¹⁷⁰ The petitioner argued that her case was distinct from *Chrisman* and previous cases because the hospital had a monopoly in Billings, Montana, and there was no other place the petitioner could have gone for her sterilization procedure.¹⁷¹ The question, then, was whether the

Tomarkin v. Ward, 534 F. Supp. 1224, 1229 (4th Cir. 1986) (stating that a former state prisoner could not recover against a hospital under 42 U.S.C. § 1983 unless the hospital was deliberately indifferent to the medical needs of the prisoner); Calvert v. Sharp, 748 F.2d 861, 863 (S.D. N.Y. 1984) (finding that the professional actions of a private physician does not establish that the physician "act under the color of state law when providing medical services to an inmate") (citation omitted).

163. *Id.* at 896.

164. *Id.* at 895.

165. *Id.* at 895–96. In *Watkins*, the hospital received Hill-Burton Funds. *Id.* at 896.

166. *Watkins v. Mercy Med. Ctr.*, 520 F.2d 894, 896 (1975) (quoting *Ascherman v. Presbyterian Hosp. of Pacific Med. Ctr.*, 507 F.3d 1103, 1105 (9th Cir. 1974)) ("The mere receipt of Hill-Burton funds . . . is not sufficient [sic] connection between the state and the private activity of which appellant complains to make out state action.").

167. 523 F.2d 75 (D. Mont. 1975).

168. *Id.* at 75–76.

169. *Id.* at 76.

170. *Id.*

171. *See id.* at 77 (citing *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 360 (1974)) ("[P]rivate conduct may not be regarded as that of the state unless the state is involved in the specific activity complained of, and that the monopoly status of a private . . . company did not in itself or in combination with state regulation and the fact that an essential public service was involved, constitute 'state action.'") (emphasis added).

monopoly status of the private hospital alone or combined with government funding established state action.¹⁷²

However, seven years later, the *Taylor* court quoted the Supreme Court in *Jackson* when it stated in dicta that “there is ‘insufficient relationship between the challenged actions of the entity involved and their monopoly status.’”¹⁷³ Ultimately, the court upheld the lower court’s ruling that no state action existed, and therefore, no relief could be granted for a § 1983 claim.¹⁷⁴ A monopoly simply is not enough to find that a private hospital was a state actor, or operated under color of state law.¹⁷⁵

In 2009, the U.S. Court of Appeals for the Seventh Circuit relied heavily on the Supreme Court’s decision in *West* to hold that a private hospital that provided emergency care to a prisoner could not be considered a state actor.¹⁷⁶ In *Rodriguez v. Plymouth Ambulance Service*, the court concluded that while the Supreme Court emphasized in *West* that the contractual relationship between the state and the provider was not dispositive of the state actor analysis,¹⁷⁷ it comes into play when:

[D]etermining whether a private health care provider has entered into its relationship with the state and the prisoner on a *voluntary* basis . . . *private organizations and their employees that have only an incidental and transitory relationship with the state’s penal system usually cannot be said to have accepted, voluntarily, the responsibility of acting for the state and assuming the state’s responsibility for incarcerated persons.*¹⁷⁸

While the conclusion in *Rodriguez* that the private hospital was not a state actor was based largely on its obligation under the Emergency Medical Treatment and Active Labor Act (“EMTALA”) to treat any and all patients who needed emergency services regardless of their custodial status,¹⁷⁹ the holding could be applied in the context of any private hospital providing basic medical care to a prisoner while under no specific contract with the state to provide such care.¹⁸⁰ This analysis would be particularly true where

172. *Id.* at 77 (discussing whether the monopoly status of a hospital or receipt of government funds, among other things, suggests state action). Interestingly, the U.S. Court of Appeals for the Sixth Circuit, as discussed earlier in the section, relied on the monopoly of the hospital to infer state action. *Meredith v. Allen Cnty. War Mem’l Hosp. Comm’n*, 387 F.2d 33, 35 (6th Cir. 1968).

173. *Taylor v. St. Vincent’s Hosp.*, 523 F.2d 75, 78 (9th Cir. 1975) (quoting *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974)).

174. *Id.*

175. *Id.*

176. *Rodriguez v. Plymouth Ambulance Serv.*, 577 F.3d 816, 827 (7th Cir. 2009).

177. *Id.*

178. *Id.* (emphasis added).

179. *Id.* at 827–28.

180. *See id.* at 828 (stating that the fact that a hospital has to provide emergency medical care to prisoners does not mean that it assumed the penological mission of the state).

a private hospital and its providers would be exercising independent professional judgment and not carrying out some state objective.¹⁸¹

Any analysis of whether a private hospital would be considered a state actor for purposes of liability under a § 1983 claim is fact-intensive.¹⁸² Recent case law indicates that it is unlikely a private hospital with no existing formal relationship with a prison would be considered a state actor.¹⁸³ Private hospitals do not discriminate against the types of patients seen in its facility, and they are required to exercise independent professional medical judgment regardless of the status of the patient.¹⁸⁴ Private facilities may choose to contract with prison systems to render medical care on an as-needed basis.¹⁸⁵ However, case law supports the conclusion that a private hospital incidentally assisting the state by treating prisoner-patients on an ad hoc basis would not qualify the hospital as voluntarily assuming the responsibility of the state.¹⁸⁶

Tangential to the prisoner analysis, but of great import, private hospitals now developing programs at the behest of the federal or state government may find they operate under color of state law, and therefore, may be exposed to liability under a § 1983 claim.¹⁸⁷ The analysis may turn on whether the hospital or facility goes beyond activities conducted in the regular course of its business at the state's behest.¹⁸⁸ Liability may arise as the hospital acts less like an independent medical entity and more like a service provider working on behalf of the state. At the very least, the question may be reasonably put forth for this activity, or any similar activity

181. *Id.*

182. *See Carmack v. Mass. Bay Transp. Auth.*, 465 F. Supp. 2d 18, 28 (D. Mass. 2006) (describing the analysis of a § 1983 claim in the case of a former train conductor alleging that the Massachusetts Bay Transportation Authority was a state actor: “[t]he inquiry, under any of these theories, is necessarily fact-intensive, and the ultimate conclusion regarding state action must be based on the particular facts and circumstances of the case”).

183. *See Rodriguez v. Plymouth Ambulance Serv.*, 577 F.3d 816, 828 (7th Cir. 2009) (distinguishing hospitals that treat inmates in an emergency situation from those that contract with prison systems for voluntary care and concluding that the former action is not sufficient to make the hospital a state actor).

184. *Id.*

185. *See id.* at 827.

186. *See id.* (observing that private facilities that only have “incidental and transitory” interactions with the penal system have not assumed the state’s responsibility).

187. *See JARED P. COLE ET AL.*, CONG. RESEARCH SERV., R43829, EBOLA: SELECTED LEGAL ISSUES (2014) (discussing programs for Ebola management, such as the required use of personal protective equipment for hospital workers, that would be mandated under the authority of the Occupational Safety and Health Administration).

188. *See Rodriguez v. Plymouth Ambulance Serv.*, 577 F.3d 816, 827 (7th Cir. 2009) (noting that a § 1983 claim in the healthcare setting must weigh the extent to which the doctor’s actions were controlled or influenced by the state).

where the government intervenes for the purpose of public safety by utilizing private resources.¹⁸⁹

B. Vicarious Liability

Ironically, even if it was determined that a private hospital was standing in the shoes of the state when providing medical care to a prisoner, the Supreme Court has explicitly held that vicarious liability cannot be imposed on a municipality under § 1983, as Congress did not intend § 1983 to create liability on states solely because it employs a tortfeasor.¹⁹⁰ Liability for the state under § 1983 exists only if the municipality itself has employed a policy of some nature that caused the constitutional tort.¹⁹¹ A private hospital pursuing a claim against the state may be frustrated, as would a patient seeking to enjoin the state based in tort by a private hospital.¹⁹²

In *Monell v. Department of Social Services*, the Supreme Court held: Local governing bodies . . . can be sued directly under section 1983 for monetary, declaratory, or injunctive relief where . . . the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers. On the other hand . . . Congress did not intend municipalities to be held liable unless action pursuant to official municipal policy of some nature caused a constitutional tort. In particular, we conclude that a municipality cannot be held liable solely because it employs a tortfeasor - or, in other words, a municipality cannot be held liable under 1983 on a respondeat superior theory.¹⁹³

The *Monell* court conducted an exhaustive review of the legislative intent of the Civil Rights Act of 1871 before overruling its prior holding that municipalities have complete immunity under § 1983.¹⁹⁴ Instead, the

189. See *Monell v. Dept. of Soc. Servs.*, 436 U.S. 658, 691 (1978) (noting that the language of § 1983 imposes liability on local governments for constitutional deprivations through informal "custom," such as activity where the government intervenes).

190. See *id.* In *Monell*, employees filed a § 1983 class action against the Board of Education and the City of New York, and individual officials, on an allegation that they were compelled to take unpaid leaves of absence ("LOA") while pregnant for medical reasons though the LOAs at the time were not indicated. *Id.* at 660–61.

191. See *id.* at 691 (finding that a policy, either formally adopted or even custom of a government actor, creates § 1983 liability).

192. *Id.* at 690–91.

193. *Id.* at 659 (citing *Monroe v. Pape*, 365 U.S. 167, 168 (1961)).

194. *Id.* at 667–91.

Court held in *Monell* that municipalities could be sued, but not held vicariously liable.¹⁹⁵

While the *Monell* court chose not to explore whether a private corporate employer may be exposed on a respondeat superior theory, other courts have held that a corporate employer may not face such exposure because of the torts of its employees.¹⁹⁶ At least one court concluded that this general principle would undoubtedly apply in the context where a prisoner sued a private hospital in a § 1983 claim.¹⁹⁷ In *McIlwain v. Prince William Hospital*, the U.S. District Court for the Eastern District of Virginia granted a hospital's motion for summary judgment related to a prisoner's claim that the hospital failed to inform him of a medical condition.¹⁹⁸ The hospital emergency provider obtained an HIV test without the prisoner's consent, the test came back positive, and a second provider for the correctional facility never informed the prisoner after the hospital physician had relayed the information.¹⁹⁹ The prisoner alleged constitutional violations for failure to notify him of his positive test, thus depriving him of an opportunity to obtain treatment and resulting in personal harm and harm to his wife when he continued sexual relations.²⁰⁰ On the issue of the hospital, the court granted the motion for summary judgment, but allowed the contractual physician case to proceed due to disputed facts.²⁰¹ The court noted that, unless a private hospital has a policy that violates § 1983 on a corporate level, the hospital could not be held liable for any of the acts of its employees or providers even if it is deemed a state actor for § 1983

195. See *id.* at 691 (concluding that the language of the statute supports that interpretation because it allows person B to become liable for A's tort only if B "caused" A to subject the third party to the tort; a simple employee/employer relationship is not enough to create liability); see also *Iskander v. Village of Forest Park*, 690 F.2d 126, 128 (7th Cir. 1982) (finding a private store not vicariously liable under § 1983 for acts of its employees); see *Powell v. Shopco Laurel Co.*, 678 F.2d 504, 504, 506 (4th Cir. 1982) (explaining that an individual who was beaten by a security guard could not recover from the guard's employer); see *Draeger v. Grand Central, Inc.*, 504 F.2d 142, 146 (10th Cir. 1974) (holding a department store not liable for actions of an off duty police officer); see *Estate of Iodice v. Gimbels, Inc.*, 416 F. Supp. 1054, 1055 (E.D.N.Y. 1976) (finding a department store not liable for false arrest by a security guard).

196. See *McIlwain v. Prince William Hosp.*, 774 F. Supp. 986, 992 (E.D. Va. 1991) (dismissing claims against the hospital because no policy or custom led to the failure to tell the plaintiff about HIV test results, but allowing the claim against the doctor who possibly knew about the test results to proceed).

197. *Id.* at 992.

198. *Id.* at 987.

199. *Id.* at 988.

200. *Id.*

201. *Id.* at 992.

purposes.²⁰² Such a conclusion further reduces the potential liability on a private hospital in the context of treating prisoners.²⁰³

Of special note, however, the *McIlwain* court pointed out when the state might fall prey to a § 1983 claim based on the actions of a private hospital.²⁰⁴ In citing *Modaber v. Culpeper Memorial Hospital*, the *McIlwain* court referenced in dicta: “[A] state becomes responsible for the acts of a private party such as a hospital if the party “acts (1) in an exclusively state capacity, (2) for the state’s direct benefit, or (3) *at the state’s specific behest.*”²⁰⁵

The implication of *McIlwain*, then, is that if the state charges a private hospital with performing certain activities at the state’s request, § 1983 liability may attach.²⁰⁶ In essence, a nexus created by contract, exclusivity, or operationalizing a state-mandated or collaborated program may open the door to a claim against the state based on private action.

C. *The Prison Litigation Reform Act of 1995*

In 1996, Congress effectively enacted a roadblock of sorts for prisoners wishing to file malpractice claims (or any civil claim for that matter) in federal court in the form of the Prison Litigation Reform Act (“PLRA”).²⁰⁷ PLRA was created in response to the volume of cases being brought by prisoners that effectively clogged the court system.²⁰⁸ The PLRA applies to civil actions brought by prisoners including those offenders housed in the military centers, juvenile facilities, drug treatment

202. *McIlwain*, 774 F. Supp. at 990.

203. *Id.* at 989.

204. *Id.* In *Modaber*, a physician claimed he was denied due process under the 14th Amendment by the hospital by revoking his staff privileges. *Modaber v. Culpeper Memorial Hosp., Inc.*, 674 F.2d 1023, 1024 (4th Cir. 1982). The district court dismissed for failure to state a claim, and the Court of Appeals affirmed. *Id.* Congruent with well-established precedent, the mere receipt of Hill-Burton federal funds was insufficient for a private hospital to be deemed a state actor. *Id.* at 1026–27.

205. *McIlwain*, 774 F. Supp. at 989 (quoting *Modaber*, 674 F.2d at 1025) (emphasis added).

206. *Id.*

207. Prison Litigation Reform Act (PLRA), 42 U.S.C. § 1997e (1994 ed. & Supp. II); see *Porter v. Nussle*, 534 U.S. 516, 524–25 (2002). For a comprehensive analysis of the PLRA including an explication of judicial interpretations of each nuanced element see John Boston, “The Prison Litigation Reform Act” The Legal Aid Society Prisoner’s Rights Project (Feb. 27, 2006), http://www.law.yale.edu/documents/pdf/Boston_PLRA_Treatise.pdf.

208. 42 U.S.C. § 1997e(h); 28 U.S.C. § 1915(h); 28 U.S.C. § 1915A(c). See also *Porter v. Nussle*, 534 U.S. 516, 524 (2002) (noting that Congress passed the PLRA to limit the number of suits brought by prisoners and improve the quality of the issues before the court in addition to creating an administrative record).

residential houses, and private prisons.²⁰⁹ Courts are authorized under the statute to dismiss certain cases brought by prisoners:

The court shall on its own motion or on the motion of a party dismiss any action brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility if the court is satisfied that the action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks monetary relief from a defendant who is immune from such relief.²¹⁰

Courts have routinely applied this authority to medical malpractice claims, and the case law is vast regarding the various elements of the statute.²¹¹ Pursuant to the statute, a prisoner must exhaust all other administrative remedies prior to bringing an action.²¹² The case law surrounding “exhaustion” questions among other PLRA actions is nuanced and complex.²¹³ For the purposes of this article, the reader should be aware that the statute was enacted to improve the quality of potential actions while at the same time provide an opportunity for custodians to address complaints by prisoners before seeking a judicial remedy.²¹⁴

V. CONCLUSION

Prisoners at private hospitals are entitled to receive the same medical care as any other patient in the general population. Because of additional obligations of the government to oversee and ensure adequate health care,

209. 42 U.S.C. § 1997e(h) (2013). Of note, “Prisoner” is defined in subsection (h) as “[A]ny person incarcerated or detained in any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program.” 42 U.S.C. § 1997e(h) (2013). Several cases have interpreted the scope of this definition to exclude both the deceased prisoner and relatives. *See, e.g.,* Rivera-Quinones v. Rivera-Gonzalez, 397 F.2d 334, 339–40 (D.P.R. 2005) (interpreting the PLRA definition of prisoner to exclude deceased prisoners).

210. 42 U.S.C. § 1997e(c)(1) (2013).

211. 42 U.S.C. § 1997e(a) (2013) (“No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.”). *See also* Spruill v. Gillis, 372 F.3d 218, 235 (3rd Cir. 2004) (noting that a prisoner’s allegations of medical malpractice are not sufficient to establish a Constitutional violation).

212. 42 U.S.C. § 1997e(a) (2013).

213. *See* Porter v. Nussle, 534 U.S. 516, 529–30 (2002) (analyzing the exhaustion requirement as it applies to the phrase from the statute “prison conditions” and noting that the meaning is not immediately clear cut).

214. *See* Kathryn F. Taylor, *The Prison Litigation Reform Act’s Administrative Exhaustion Requirement: Closing the Money Damages Loophole*, 78 WASH. U. L. REV. 955, 956 (2000) (noting that the law was passed to curb the dramatic number of frivolous lawsuits while also mandating administrative remedies be exhausted before a suit is filed).

the processes for assessing and treating prisoners are inherently encumbered by additional administrative needs to ensure that rights are not being violated at the same time the risks to the health care entity are mitigated. The prisoner simply has the right to consent to their own medical care, though the standard by which the penal system is accountable for ensuring care is rendered is not the same as for the general population.²¹⁵ Prisoners are ethically entitled to donate and receive organ transplants,²¹⁶ however, the policy governing the extent to which this is allowed is state-by-state.²¹⁷ Medical negligence is not enough for a prisoner to claim a constitutional violation, though an individual malpractice claim is an option against a private health care entity.²¹⁸ In essence, for private hospitals and providers, the standards by which they would be held accountable would vary depending on the role at the time of health care delivery, and the type of action the prisoner files.

215. *See supra* section III.A.

216. *See supra* section III.C.

217. *Id.*

218. *See supra* section IV.